Health Information Technology Council Meeting

May 22, 2015

Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Minutes	10 min
4. Executive Team Nomination Process	5 min
5. Review of Progress to Date	20 min
6. Update on Evaluation of Short Term Options	25 min
7. Proposed Process Moving Forward	25 min
8. Process for Responding to Questions	15 min
9. Next Steps	5 min
10. Appendix	

Executive Team Roles and Nomination Process

Summary of Roles and Responsibilities as per the HIT Charter:

- Includes the co-chairs and three members from the council representing the major stakeholder groups (Consumer Advocates, Payers and Providers).
- The non-co-chair members will be included in the agenda prep calls to assist in agenda development and identify any issues brought forth by council members.
- After the meeting, HIT Council members are invited to raise process and content issues with the members of the executive team.

Nomination Process:

- Call for nominations at the HIT Council Meeting
- Electronic ballets will be sent to each HIT member and results sent back to Virginia Sullivan

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HIT Council: Goals and Scope

Develop recommendations for the Healthcare Innovation Steering Committee with respect to HIT use by SIM participants (e.g. hospitals, practices, state agencies, consumers) to achieve the goals of the SIM initiatives.

Specific responsibilities and deliverables (outcomes) included in the council's scope include:

- **Review of the current and proposed technologies** cited in the SIM grant to understand capabilities and uses for Test Model
- Work collaboratively and actively support **two way communications** with the other SIM workgroups and councils to develop the HIT design that aligns with SIM initiatives.
- **Recommend technologies** to support the SIM initiatives
- **Participate** with the SIM HIT Steering Committee and other SIM work groups and councils.
- **Create High level schema** of HIT solution
- Describe SIM HIT solution **implementation approach**

HIT Council: Progress to Date

- **The Quality Council suggested that two EHR-based clinical measures be examined for 2016** to inform their deliberations regarding the selection of measures and implementation scope and timing[1]
- **A two-staged approach** is to pursue the implementation of a subset of clinical measures while developing the longer term solution
  - Short Term: Implement subset of clinical measures for 2016 with limited analytic capabilities
  - Long Term: Implement full clinical measure set with bidirectional analytic capabilities
- **The solutions being evaluated for the two measures to be implemented in 2016 are APCD and Zato**. An update on the evaluation process will be provided today

1) Final measure set target date to be determined pending receipt of base rate and NCQA performance data.

2) Quality Council has thus far proposed full measure, limited analytic stage one solution.

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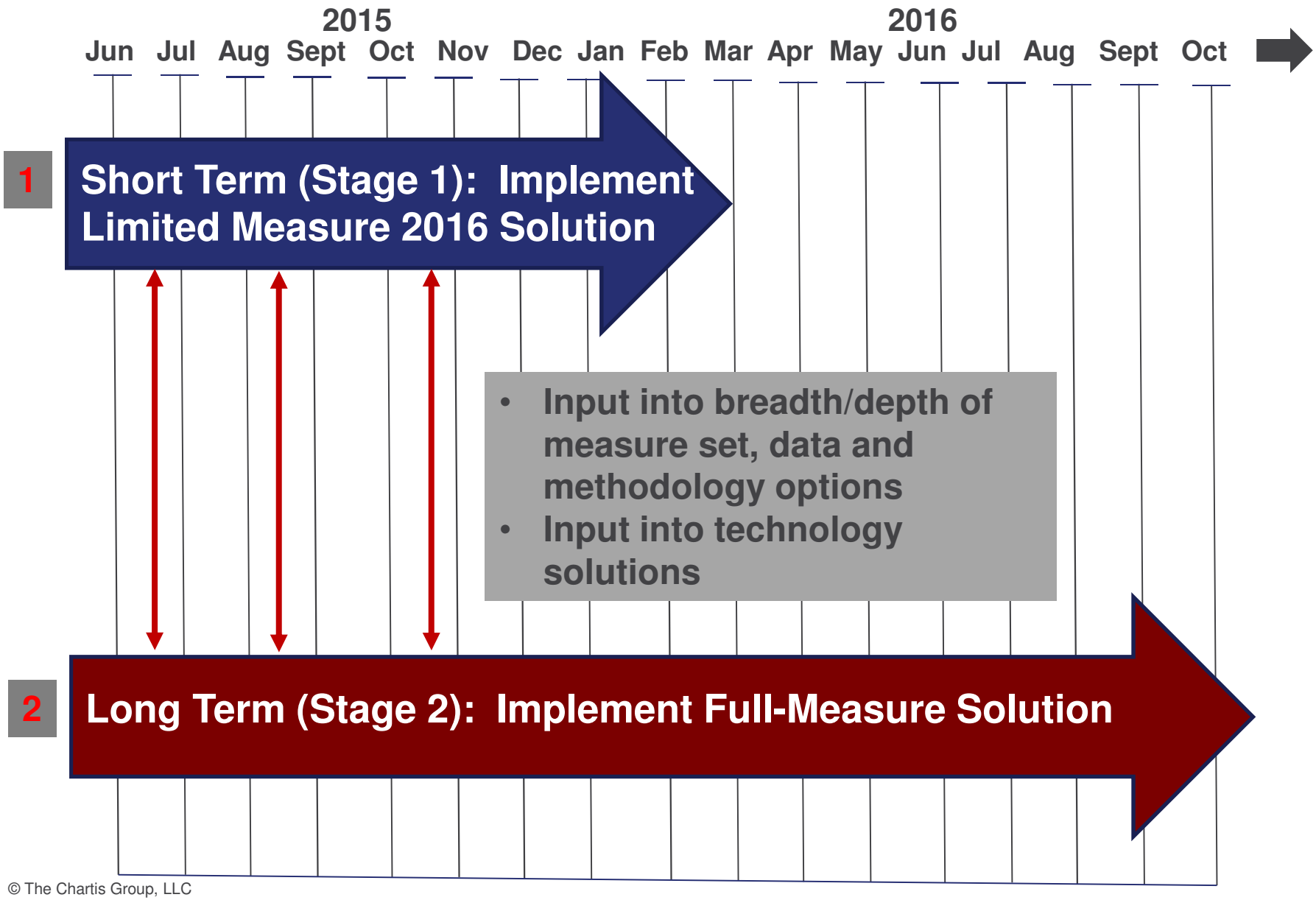
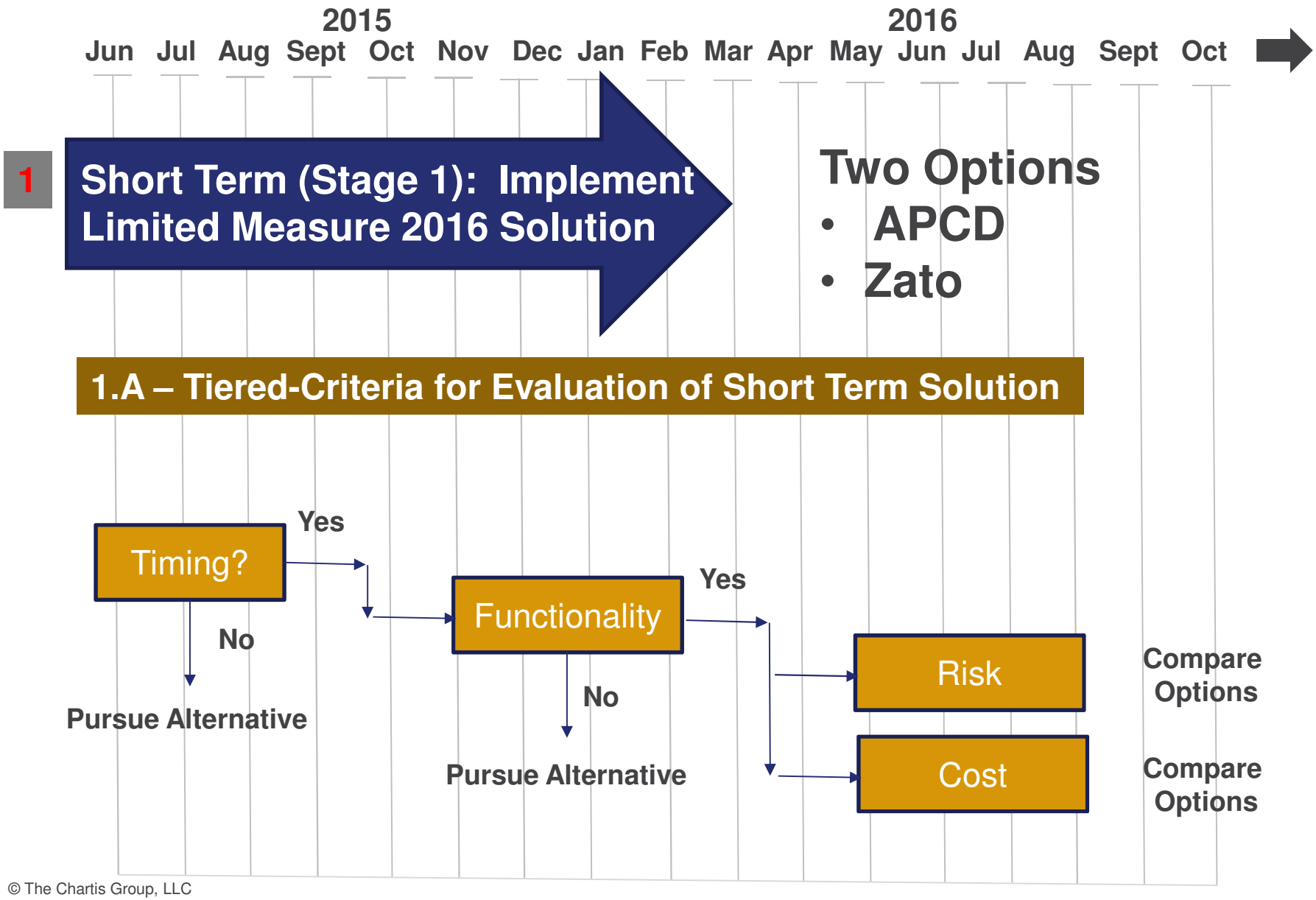
Update on Evaluation Process



Update on Evaluation Process

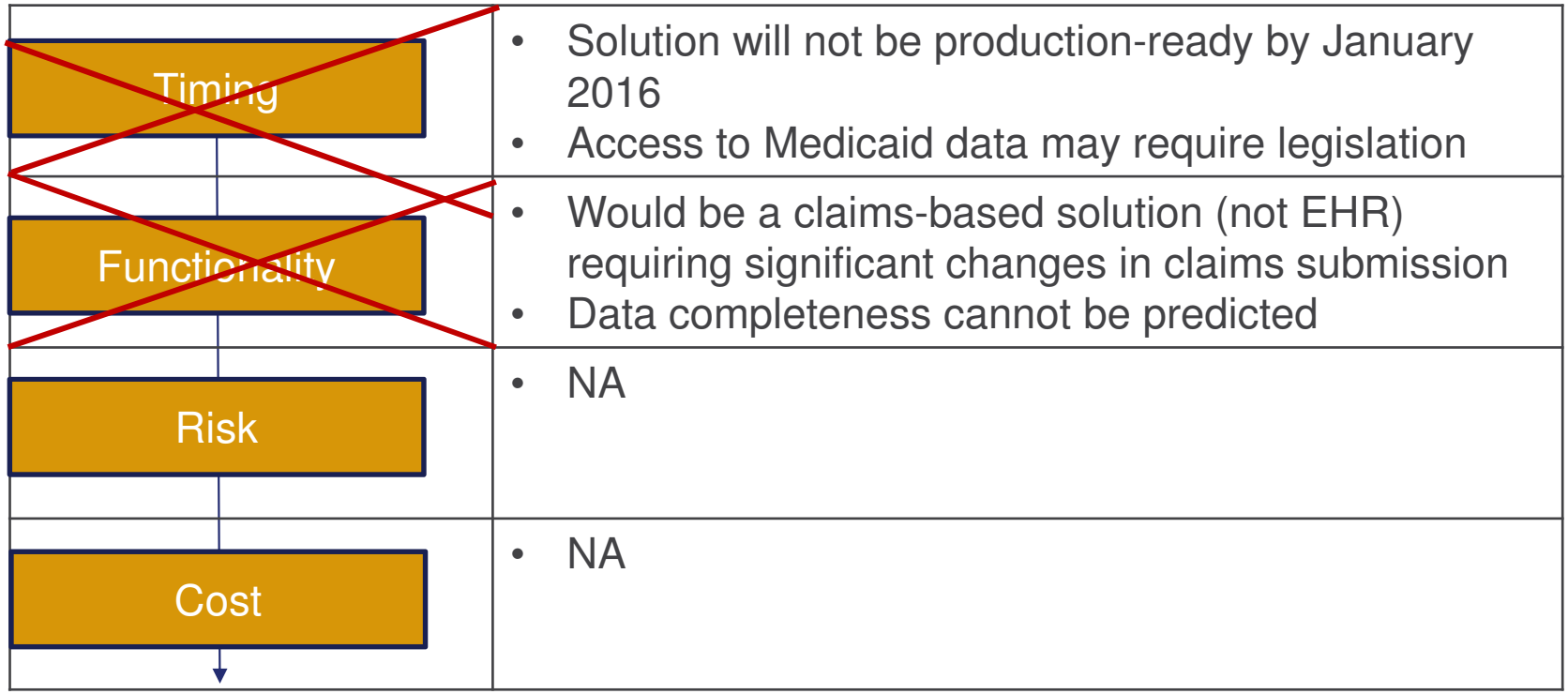


Update on Evaluation Process

1.A – Tiered-Criteria for Evaluation of Short Term Solution

APCD - Evaluation To Date[1]

No



1) Based on responses questions provided by xyz

Update on Evaluation Process

1.A – Tiered-Criteria for Evaluation of Short Term Solution

Zato - Evaluation To Date[1]

? – Need Additional Information

Timing	• Purchased and installed for Non-SIM purpose • Awaiting input as to potential timing.
Functionality	• The proposed approach is to capture an eCQM measure after the provider has calculated the measure in their EHR. Unclear as to whether there is the required flexibility in the calculation of the eCQM to meet the SIM-proposed measure in terms of level of detail (M'caid and Commercial, Payer-specific) and methodology. Need to explore whether the measure can be calculated on a re-aggregated set of patients without violating eCQM methodology. • Another potential option is to have Zato extract data and perform calculation
Risk	• Initial concern that this might create a resource burden for participating providers
Cost	• NA

1) **Need approval to submit 2nd set of questions to Zato for evaluation.**

Performance Measures DG: Zato Questions

Approve for Submission

1) Will Zato provide a healthcare demonstration of their de-identified EHR-indexed solution? Can we go to the BayState Innovation Center to see Zato working with a Cerner system?

2) Please provide us with more details on how Zato will work with multiple data sources in terms of indexing/pulling of the data, and the timeframes to complete.

3) What is the impact on the provider resources – short term and long term to support?

4) Please explain what is stored in the indices. Diagrams, examples and a physical demonstration would be useful to understand this.

5) What is the tool to store data and to do reporting from that data? How does the data mart or warehouse configure into the system ?

6) What analytics capabilities are available for immediate use with Zato? What tools are available to build on the analytics starter set? What language are they written in?

Performance Measures DG: Zato Questions

Approve for Submission

7) There was concern that data normalization could add inherent distortion into the data. Please address this concern. More specifically – how is the data normalized? Who is involved in doing the normalization? How much time might we expect to do this process?

8) Is the data always kept behind the site's fire wall? There are concerns of privacy and patient consent. Please address these concerns. Is the data encrypted at rest and in transport?

9) Many of the states are using the state HIE or a centralized database, what are the advantages of edge servers beyond keeping the data behind the firewall?

10) Have you followed a "proof of concept" methodology? If so, can you describe the major steps and where it has been used?

11) How does your work in intelligence translate into healthcare? In particular it would seem that provider and vendor expertise would be needed to work on the schema and mapping for the indexing.

12) Other questions?

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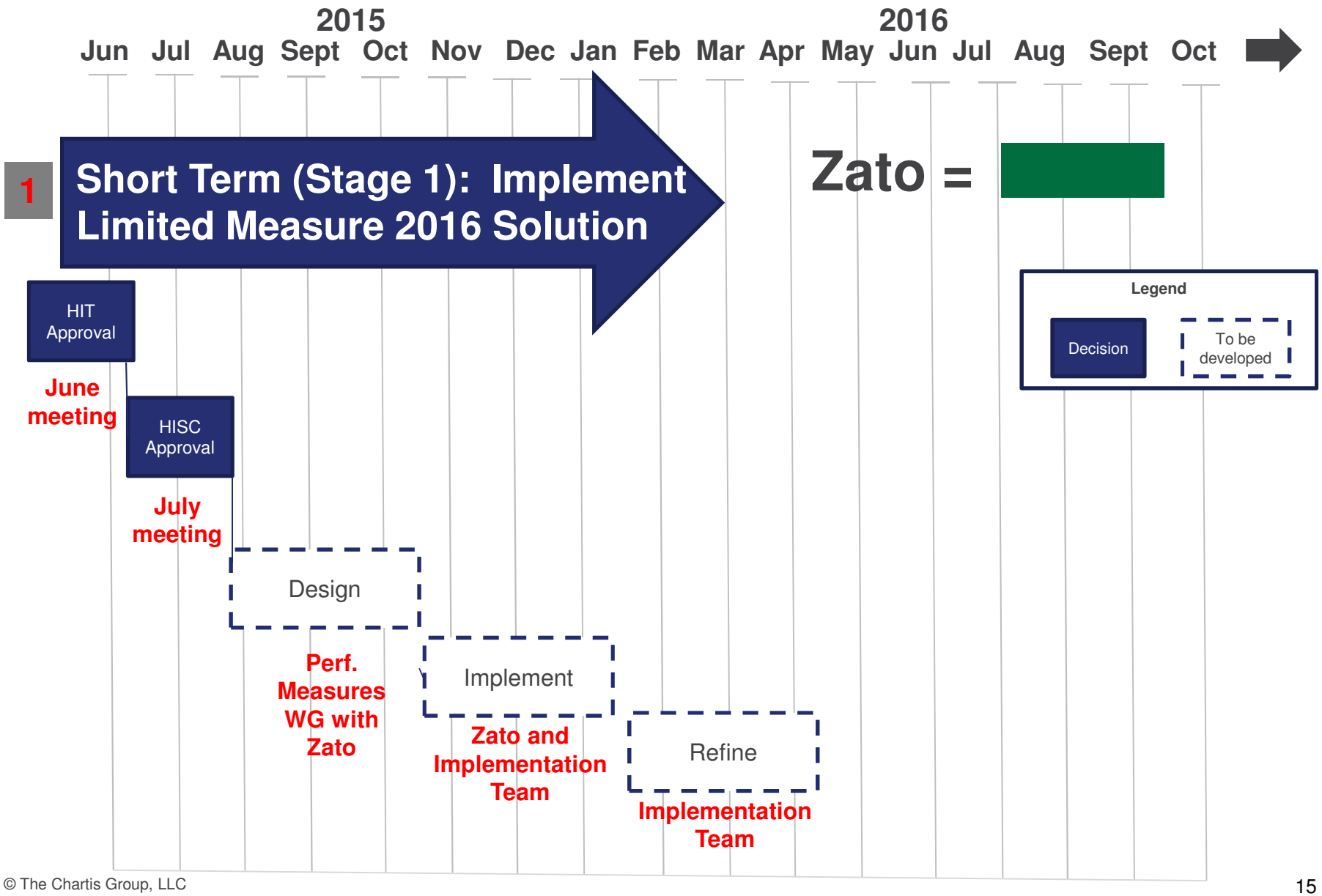
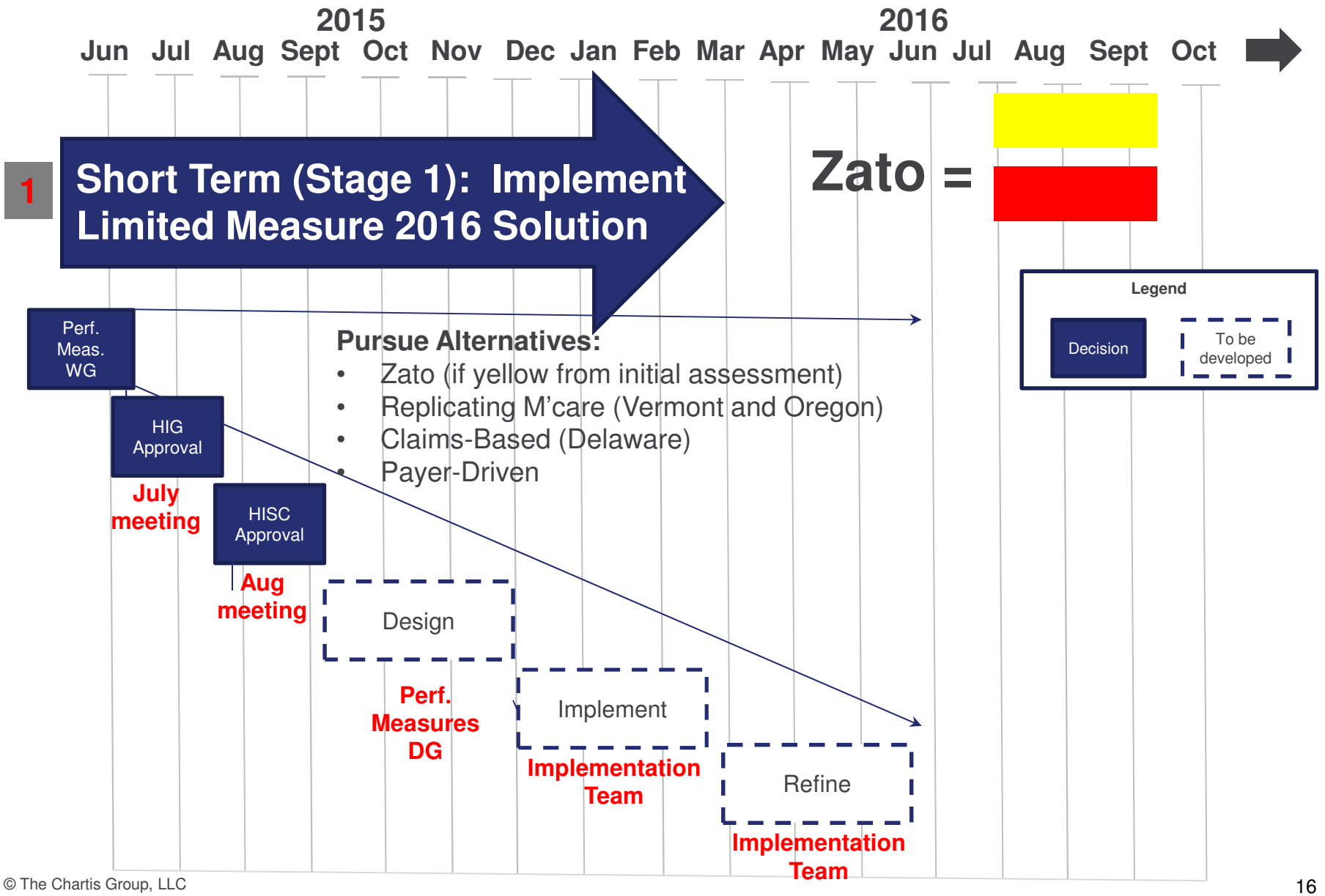
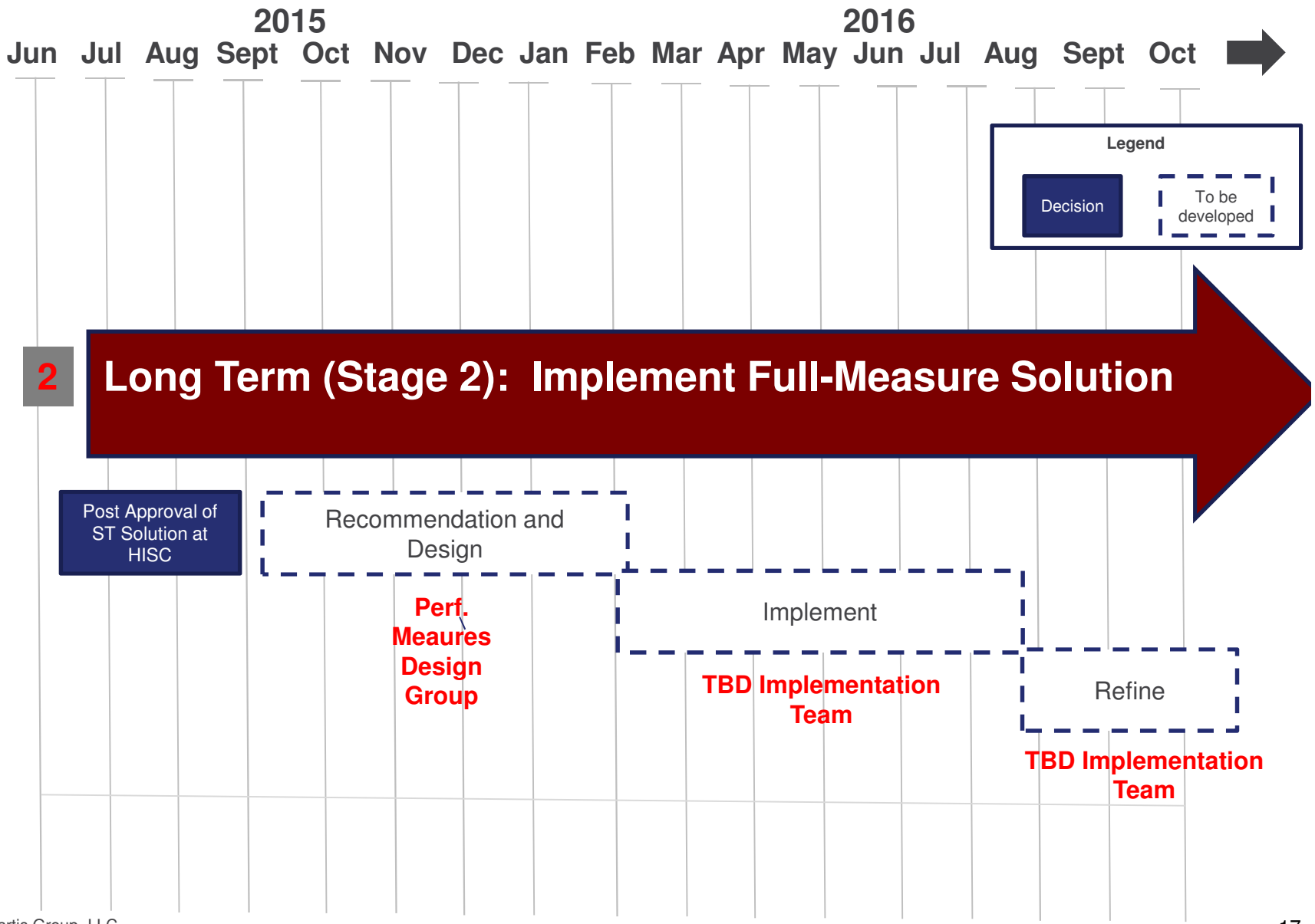
Proposed Process Moving Forward



Proposed Process Moving Forward



Proposed Process Moving Forward



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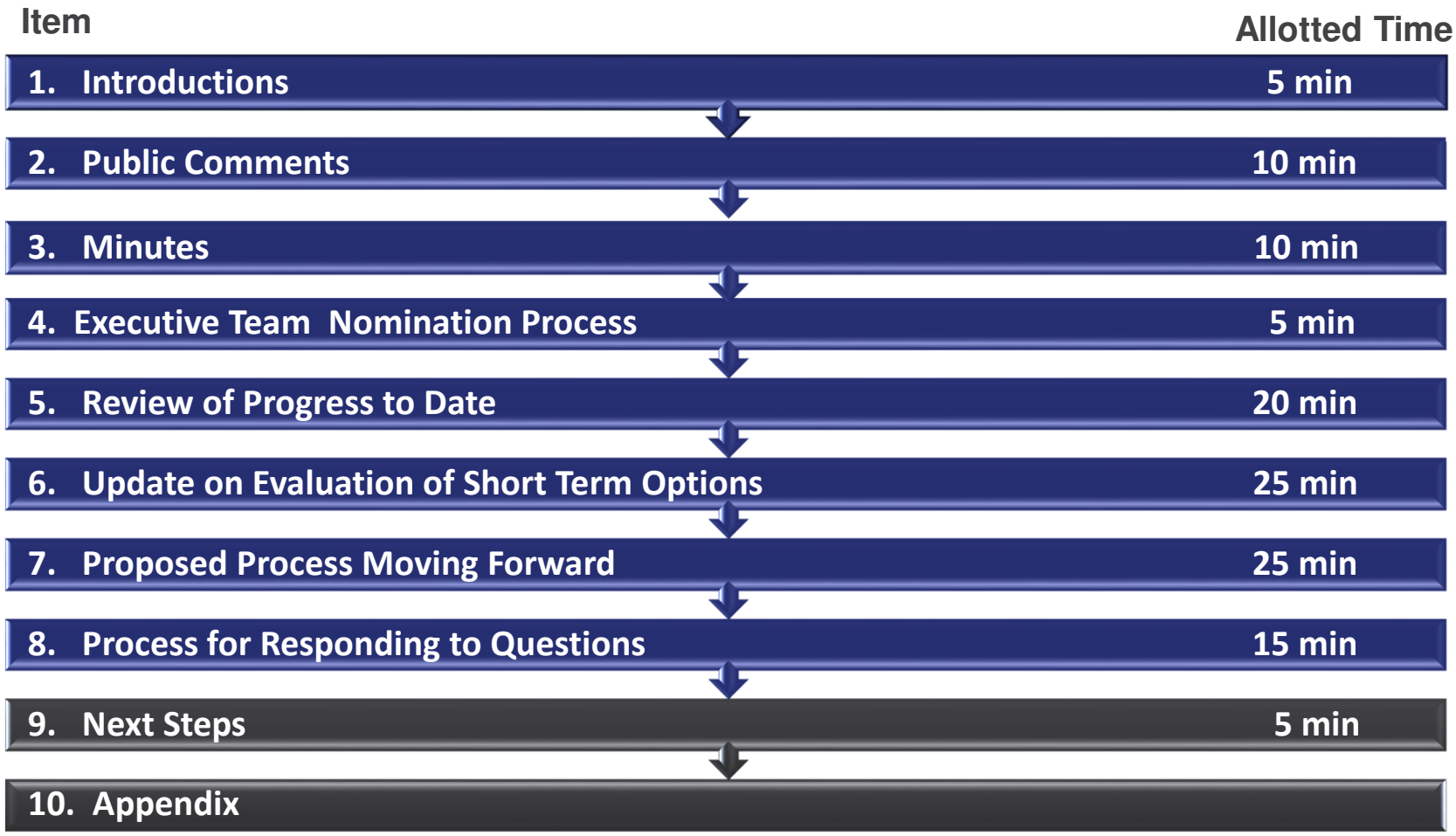

Proposed Process for Responding to Questions

- Any questions regarding the HIT Council should be submitted to Mark Schaefer of the SIM PMO via email
- As possible, questions and their answers will be included in future HIT Council Discussion Documents
- Reference to these questions will be included in the Agenda and members can request discussion of these questions via the Chair prior to or during the Council meeting
- A set of questions were submitted since the last HIT Council meeting and the responses are included in the Appendix of the discussion document

HIT Council Questions

Questions have been raised by council members to individuals and in work groups. To allow other members to weigh in, to allow for public dialogue and maintain trust, the questions will be reviewed and discussed by the entire HIT council.

1. The Executive Document for the **Connecticut Healthcare Innovation Plan** details the goals for IT. How does this relate to the SIM HIT Goals?
   - **Advanced payer and provider analytic capabilities** to support improvements in care delivery and health, with the eventual introduction of cross-payer ("aggregate") analytics made possible by Connecticut's All Payer Claims Database (APCD) and advancements in health information exchange. This is a capability that is anticipated to be defined as part of the stage 2 bi-directional analytic solution defined by Quality Council
   - **Creation of multi-payer portal for providers and consumers to allow easier access to** information and better decision making by providers and consumers. In preparation of model test grant, the HISC had to consider the priority investments with the limited investment required. A combination of lack of widespread support for provider portal and limited resources led both of these elements to be set aside. DSS had proposed supporting a state sponsored patient health record but SIM budget for this was eliminated due to CMMI required reduction requirement

HIT Council Questions

Questions have been raised by council members to individuals and in work groups. To allow other members to weigh in, to allow for public dialogue and maintain trust, the questions will be reviewed and discussed by the entire HIT council.

1. The Executive Document for the **Connecticut Healthcare Innovation Plan** details the goals for IT. How does this relate to the SIM HIT Goals?
   - **Guidelines for care management tools.** Since Connecticut has a large number of small provider practices, we will establish shared guidelines rather than mandatory procedures for adopting care management tools. This is under review as part of the SIM model test. The proposed solution set is a viable option that we will likely explore for the long term solution.

   - **Standardized approach to clinical information exchange** to accelerate providers' use of direct messaging for secure communication and coordinated care delivery across different sites of care. Our plan begins with point to point communication and evolves to a comprehensive, statewide, health information exchange. This continues to be a longer term goal for the SIM Model test.

HIT Council Questions

2. **Would a reasonable strategy be to stand up the edge server connected to the APCD and** all commercial laboratories to meet the majority of quality/performance metrics? Additional data into medications dispensed (not PBM data) would further improve the capabilities to report "current status" of population health? Obviously metrics can be extracted although perhaps limited without prospective data connection at the provider level. A lot of what we need is not available through claims and lab data but it may not be an efficient use of resources. At best it would be a partial solution.
3. If exchange for data is imperative, should consideration be given to developing the **direct messaging** capabilities? We are waiting for requirements from the Practice Transformation Task Force.
4. **Are we asking for a "centralized" population health effort, or are we to empower each provider to manage individual patients?** Depending on the decision, accessing the APCD, medications, etc. through direct would be wise. The answer begs to the decision for a HIE/RHIO. Should we discuss from a state perspective the direction necessary to develop the IT infrastructure.
   At the time the grant was written, HIE was too far in the future to be a consideration during the SIM Model Test performance period
5. From the conversation during the last meeting, what was the nature of the **concern for conflicts of interest**? Clarity was requested regarding the process an individual responsibility to disclose conflict and recuse.

HIT Council Questions

6. What is the method of attaining the above goals**; top-down (state level first then to the provider level) versus bottom up?** The available monies and direction of IT development really depends on the focus to provide improved patient care to state residents. Bottom up initially for 2016 solution and then work on top down for long term solution.
7. Should there be **direct communication** between the HIT Council and other Council members, especially the Quality Council? Good suggestion. There is now that QC members have joined the HIT Design Group.
8. **Readmissions data may already be available** via other state agencies' data sources. Should we consider these to minimize additional work? For example, the Department of Public Health receives readmission data from the Connecticut Hospital Association on an annual basis. Will be discussed as part of the process.
9. **When will the Quality Council deliver the January 2016 requirements** and those needed for future years. The HIT Council needs to design the solution with both a short and long term lens, even if the long term solution replaces the 2016 solution. The PMO has proposed a measure completion date for measure set of 7/16/15
10. Why can't we use the **eCQM** (electronic Clinical Quality Measures) file? It has the measures information and is a requirement for MU Stage 2? Technology is not ready for production use –still not mature.

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Next Steps

- Submit 2nd Set of Questions to Zato
- Conduct additional research on proposed alternatives
- Prepare for final recommendation regarding Zato for short term solution for next HIT Council Meeting

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Appendix

- **Response to APCD Questions**

Performance Measures DG: ACPD Questions and Responses

1. What is the timeframe that the APCD would be operational and have data from all of the commercial payers?
   Answer: We intend to have data available by the end of 2015 and operational for use by 1st Quarter of 2016.

2. Medicare data is stored differently. Can the APCD still report on measures for commercial and Medicare?
   Answer: We can procure Medicare data and it can be standardized to the commercial data structure. (This data standardization would have been applied across Medicaid data as well.) We can then produce data feeds or create report for commercial and Medicare payers.

3. What are the analytics tools and standard reports that are available with the APCD?
   Answer: We would have Statistical Analysis System (SAS) and SQL available on APCD infrastructure. We can also create report specific to SIM's needs for repetitive reporting.

Performance Measures DG: ACPD Questions and Responses

4. Given that APCD may not be able to share identified data, how does that impact reporting for SIM?
   Answer: There will be information available on the eligibility or claims file that could enable us to report on studying/reporting impact by SIM. Secondly, we can also use external data from SIM interventions sent out upstream to our data vendor for linking up with identified data, enabling us to create information on deidentified data for impact studies. One part of the analysis that cannot be performed is the federal (CMMI) evaluation which may require fully identified data.

5. Are there any legislative changes required before APCD data can be used for SIM purposes as currently proposed?
   Answer: Yes, it may be needed ultimately. But we have to articulate the reasons and the detail of the information needs. One obvious reason is the CMMI's need to evaluate performance which may require fully identifiable data. Secondly, if APCD data is needed to develop performance report cards for providers, then there may be a convincing reason to share patient identifiable data particularly for closure of gaps. There is an allowable provision in HIPAA, i.e., identifiable data used for Treatment and Coordination (T&C) purpose which can be invoked/used as a rationale for identifiable APCD data. Lastly, I have not explored it but it is possible that identifiable Medicare data could be shared with CMS's approval. I do not think state legislation (on data disclosure) is binding on Medicare data.

Performance Measures DG: ACPD Questions and Responses

6. What percent of the data is missing and/or not reported for the data elements related to the measures selected for SIM reporting?
   Answer: It is very early to say what will be missing. Broadly speaking I can say that almost 50% of the commercial data will be missed if commercial carriers withhold ASO data. The only silver lining is that Aetna just informed us that they would submit ASO data along with the fully insured data unless employers opt out explicitly. I encourage all of you to convince other carriers not to opt out submitting ASO data. Secondly, I had discussed in the last meeting, in the context of two metrics needed to measure clinical performance, that certain esoteric variables like CPT Level II may be underreported as this is a new data and coding schema that many providers do not usually code in practice. Thirdly, we do not know how the carriers will code the participants in shared savings program. Are they going to use the existing product or plan field(s) or are they going to pass on that information through provider attribution, these details are not yet known.